Bonsoir, Good evening!

Pour commencer, je voudrais mettre la table en partageant avec vous ce très brève vidéo. It is titled: IF AIR TRAVEL WORKED LIKE HEALTH CARE. As the saying goes, “there is truth in jest”, and this video does raise serious issues that we must discuss. And so permit me to begin…

Après avoir passé plus de 40 ans dans le réseau de la santé et des services sociaux en tant que chirurgien, enseignant, chercheur, et gestionnaire, je suis heureux de partager avec vous ce soir mes idées sur la direction que nous devrions poursuivre dans l’avenir. Il est formidable de voir réunis dans cette salle nos trois conseils d’administrations, ainsi que nos fondations. I also note the presence of the principal of McGill University, Suzanne Fortier, and the Dean of the Faculty of Medicine, Dr. David Eidelman.

We all serve the same community, we all provide services to the same population, yet none of us can do it all. If we are to provide the full continuum of services to our patients and users, we must work together. This is very much what I want discuss with you tonight.

I’ve been invited to share my vision of our future and in so doing; I intend to address three topics:

- The current state of our health system and how we got here;
- The new forces now reshaping our world and emerging alternatives to better serve our patients and users;
- And third, I will share my vision of how we can and should leverage all of our resources, our traditions, our strengths and passions, by creating a true McGill Health Network.

Please understand that my thinking and my words are guided by one central overriding principle:
IT’S ALL ABOUT THE PATIENTS.

How their needs, their habits, their expectations, are changing. How we should organize to service their needs more efficiently and effectively. Of course, our institutions have constraints, our employees have needs, and we must attend to those. But from a moral perspective, our primary responsibility, for all of us and our employees, is to be organized in such a way that we feel we are answering our patients’ needs.

1 – So how did we get to where we are?

In 1821, the Montreal General Hospital opened its doors, which led directly to the creation of the McGill Faculty of Medicine. From then on until today, the model remained basically unchanged. For people to access health care, they had to go to a place where the required medical equipment, expertise and knowledge were available, and that place has always been the hospital. As equipment grew bigger and costlier the hospitals just got larger.

SLIDE 1- Computer Paradigm

Consider the computer industry that migrated rapidly from rather simple calculating devices (e.g. slide rules) to few large mainframe computers in the 1950s. This era of centralization was unavoidable because (a) the cost of the new computers was prohibitive- few could afford them; and (b) the expertise required to operate and maintain them was rather scarce.

At this point, I’d like you to remember the days you had to walk to a mainframe computer and punch cards, and what has happened since. As computing technology evolved, devices became cheaper to own and operate, smarter, smaller and more mobile.

SLIDE 2 – Healthcare Paradigm

Now let's move to healthcare. Large medical centers arose from the 1930s thru the 1970s, largely because of the need to house complex equipment, such as imaging, operating rooms and radiotherapy units. The new equipment came at a huge cost to purchase and maintain (which few could afford) and could only be operated in a highly complex environment by teams of highly trained professionals that were relatively few in numbers.

But for at least the past 10-15 years, we have been living a substantial decentralization of the system. As medical technology has evolved, many diagnostic and therapeutic interventions that could previously only be performed in large medical centers have moved out into community hospitals, clinics, doctors' offices and even the home. Moreover, with the increase in credentialing requirements for licensure of nurses and allied health professionals, much of the care previously provided by specialists and family physicians has devolved to others in smaller hospitals, clinics, and even at home to better meet the needs of patients and users.

In the context of these developments, the hospital-driven model has become increasingly unsustainable from the patient and user perspective. We deliver state-of-the-art care. Our personnel are world-class. Yet, we all know that the care that is provided is often fragmented, duplicated, associated with significant care variation, not readily accessible, and based on patient information that is inefficiently shared. This creates an added burden for the patients/users and for our resources.

This model is also unsustainable from a systemic perspective. Health ministers have been meeting this week and the message is clear- tinkering won't solve the problem. We have to look at the system itself. Health care costs continue to rise at an alarming rate, far outpacing the growth of both natural economies and household incomes. For three decades, governments have been trying to drive out inefficiency, slash reimbursement, control margins, and limit utilization, yet health care costs continue to increase. We all know that if we do not somehow regain control, we are heading into a financial wall. And we all know that simply cutting costs and rationalizing our operations will not suffice; the system itself has to change.

And finally, our health and social services network is no longer responding adequately to the changing needs of the patients and users.

2 – So how is the world changing?
SLIDE 3 – *There are 5 Driving Forces

1. People are living longer and require increasing levels of care – different types of care.

2. In addition, chronic illness is on the rise and people increasingly suffer from multiple health problems. Patients with 4 or more chronic conditions account for a third of patients and over 70% of healthcare spending.
   It is not only a question of costs but of the patients requiring access to a greater number of health care professionals in varied fields; they need to go from the hospital to the rehab center to the local clinic to the pharmacy to the CLSC, and to long-term care. Our role is to organize ourselves so that wherever they need to go, they will be greeted by professionals that have access to all of their patient information and that can provide the care and services required by the specific care trajectory of each individual patient.

3. The promise of science has never been greater. We have mapped the human genome and unlocked the genetic code of many pathogens and cancers that threaten us. We are now on the brink of a new biotechnological era, where care solutions will draw on an individual's own biology to preempt, treat and cure disease. Today's technology has translated into medical equipment that is so much smaller and portable that they can be applied not only in hospitals but also in clinics and even the home.

4. The 4thchange is the information revolution. Almost by the day, data is ever more abundant and of better quality. This opens the door to better analysis and clinical decision support and personalized care. But it also opens tremendous new possibilities for accessing information at a distance and reduces the need for our patients to go to the hospital. This information revolution is also breaking down silos and optimizing the timing and location of care.

5. Finally, we have better informed patients. The increasing availability of personal health information, combined with advances in patient engagement technology, is creating more informed and demanding patients, with the ability to choose where they are treated. By the way, the right of patients to choose their provider has been a fundamental principle of the Health and Social Services act since 1971. I endorse it and it must be retained.

> Models of care that encourage greater patient participation are demonstrating reduced costs, better patient outcomes, and higher quality- particularly for people with chronic diseases. Not only that, we now live an era of total transparency. People are organizing to rate the quality of service for everything from teaching and taxis to restaurants and travel services. Thus very soon, each organization's quality ratings will be publicly compared against that of its peers in a bid to increase transparency and improve performance.

These 5 trends combined are driving and will impose a profound transformation of health care delivery. Standing still is not an option. Our old institution-driven model is being overtaken by time.

So, where do we go from here?

3 - Towards a patient-centered continuum of care

*Research indicates there are several interdependent and mutually reinforcing elements that are required to move to high-value health care delivery that answers the needs of today and tomorrow:

SLIDE 4

A - We must organize around patients' needs

Patients today have to move around the system and accommodate to the system because it was set up to meet the needs of the institution, not those of the patient. We have to switch our focus to the needs of the patient and user and deliver service when and where required in a seamless manner. If I leave you no other message, it is important to understand this. The current system is designed around and constrained by institutional barriers.

Health systems across the world are increasingly prioritizing evidence-based models of care that require multi-disciplinary teams. In doing so, they are shifting care away from costly acute-care settings and into the community. This goal creates the need for more integrated systems that bridge existing silos of acute, long-term, primary and community care, as well as wellness and prevention programs.

At the heart of the needed transformation is changing the way clinicians are organized to deliver care. This requires a shift from today's siloed organization by specialty department and discrete service to organizing around the patient's or user's medical condition, and the need to treat not only a disease but also the related conditions, complications and circumstances that commonly occur along with it.

B - We must Measure the outcomes that matter for patients

Rigorous measurement of value is perhaps the single most important step in improving health. While it is important to have proper processes that are measured, it is the clinical outcomes for patients, relative to the cost, that must be the prime consideration. We should be asking whether we are solving their problems and allowing them to live better. That is where value resides for the user as well as for the system. Highly performing organizations have adopted protocols of care as a core operating principle and have automated systems to inform trajectories of care.

C - Finally, We must Integrate care delivery systems
There are huge opportunities for improving value as providers integrate systems to eliminate the fragmentation and duplication of care and to optimize the types of care delivered in each location.

AND SO- WHAT IS MY VISION FOR A MCGILL HEALTH NETWORK?

4 -<u>The McGill Health Network</u>

SLIDE 5 – Key Benefits

Since patients require services from many institutions, the institutions themselves have to come together if greater coordination, measurement of outcomes, elimination of fragmentation and duplication, optimization of care, and timely access are to occur.

In fact, the level at which care and services have to be coordinated is no longer the institution; it is the community itself. It is the geographical, sociological, cultural and linguistic space within which the patient moves and obtains the services he requires. Again, I repeat what I said earlier- The patient should be able to move freely within all the institutions of his natural community rather than being shuffled about because these institutions have not integrated their information systems and their care delivery services, and are bound by administrative and budgetary rules that force them to operate in silos.

I am suggesting that taken as a whole, all of the institutions that are served by McGill's Faculty of Medicine and affiliated professional schools should come together as an integrated network.

Together, we offer the full range of services needed by our patients and users. All these institutions share territory (including rehab, palliative care and long term care beds), patients, clinical and teaching staff, trainees, and in many instances the MUHC and JGH actually share clinical programs. All this to say, the three clinical organizations are complementary to each other, and require each other to be optimally efficient and effective for their full value to the community to be realized. However, since they function independently of one another, the care that is provided is often fragmented, duplicated, associated with significant care variation, not readily accessible, and based on patient information that is inefficiently shared. This creates an added burden for the patients/users, not to mention lower quality and costlier care. This needs to change.

Delivery of integrated care cannot be the result of a day by day negotiation between quasi-independent institutions in a system centered on the autonomy of the institution; this approach belongs to the past. Integrated care can only be achieved by institutions that are engaged in a network where the operating principle is cooperation and sharing of information and clinical practices.

To better serve the patient and users and more effectively deploy our healthcare and social services resources, we need a fully integrated McGill Health and Social Services network.

By design such a network would have a patient-first orientation. It would eliminate traditional institutional obstacles and permit patients and their families to move smoothly among all of the facilities to reach those that best meet their needs. This is known as a seamless continuum of care.

Ce réseau serait conçu de manière à répondre en priorité aux besoins des patients. Il établirait un continuum de soins et services à l'intérieur duquel les patients et leurs familles pourraient se déplacer facilement d'une institution à l'autre, vers l'endroit qui répond le mieux à leurs besoins. Une intégration partielle ne suffira pas.

Partial integration will not get us where we need to go. I do not believe that half measures will solve the problem. We have tried coordination through the Agences, which was not a resounding success, and we have tried cooperation agreements, which made cooperation the exception, not the rule. Given the time and effort required to make loose coordination work, we would be better served to invest that energy in building a sustainable and functional integrated network at the service of patients. We are at an important juncture: the way forward is to build a network founded upon and driven by what is best for our patients and users.

<u>Mergers vs. Networks</u>

Because of everything that has been said and written in the past weeks, I feel obligated to specify not only what I am advocating, but also what I am NOT advocating.

To be quite specific: I am NOT advocating further mergers of our institutions. I am advocating for the creation of a network of the three institutions, the MUHC, CIUSSS Centre-Ouest and CIUSSS Ouest-de-l'Île, that have been recognized as McGill University related institutions by virtue of their teaching and research relationship. McGill is a common link as is their bilingual status and their shared communities. The relationship with McGill has been a driver of quality and innovation. These three institutions represent the majority of owner-corporations that were regrouped and not amalgamated under Bill 10. This represents all of the McGill hospitals- And virtually all of their medical staff are members of the Faculty of Medicine.

My vision is to regroup these three institutions in a network under a common board of directors with a shared senior management. Every person working in that network would identify themselves as a part of this network and in dealing with patients and users; they would be thinking where in the network their patient would be best served. [Pause] Today, this is not the case. If the service a patient requires is not part of a given institution there is a tendency to think it is not that institution's problem.

Je l'ai dit et je le répète : Aucune de nos institutions ne peut à elle seule répondre à l'ensemble des besoins de nos patients et utilisateurs.
I said it before and I am repeating it: None of our institutions can deliver all of the care and services required by patients.

In such a network consisting of a substantial territory and population, and encompassing the complete range of operations with an operating budget of some 2.5 B$ it would be necessary and desirable to empower decision-making at the operational level in order to be responsive to local needs and circumstances in a timely manner. In this regard, in my vision I believe there should be director generals in the major institutions in order to ensure that these local considerations are managed according to the needs of the community level.

I, for one, firmly believe that the connection between our institutions and the community is fundamental to the vitality and effectiveness of those organisations. We must take every measure to ensure meaningful and continuous community engagement. Our laws currently allow for community-based advisory committees and in our CIUSSS at least, we have demonstrated that they work, they are effective, they produce results, they keep us firmly grounded in our community and they keep the community firmly attached to its institutions. The Council for Services to Children and Adolescents at the MUHC represents another example of the outstanding success of such committees. These advisory bodies can be implemented; anywhere the community feels it needs to tighten its links with its health-care institutions.

And I want to be clear about this- Our foundations play a crucial role, and they must be supported, and they must know they will remain attached to their institutions and can continue to raise money for them with confidence. Our institutions will retain their vocations. Our doctors and providers will be attached to institutions, as they are in our CIUSSS, where the merged and regrouped institutions continue to have local CMDP sub-committees, as allowed by the model under Bill 10. It works well, they are effective, and the preoccupations of all establishments are taken into account.

A generational opportunity

We have spent 18 months working hard to build networks. My vision is to build on that good work and continue to improve upon it, not to scrap it and start all over again.

I know some people are tired, weary of any further change. I understand this. But change is upon us and if we do not embrace it, it will overwhelm us. The disruptive forces that are transforming health care systems everywhere in the world are unstoppable. At the health minister's conference, earlier this week, we heard it said from everyone who has an interest in our system: we have huge problems that money cannot solve; we have to address the system itself.

The only remaining question is: do we want to lead it? To design it as best we can? Or do nothing and accept whatever comes our way? And I want to repeat- half measures will not solve our problems; they will simply prolong the disruption!

The task at hand is far from insurmountable. *Nous profiterons des nombreuses expériences récentes de réorganisation de systèmes de santé au Canada et aux États-Unis. Nous savons ce qui fonctionne et ce qui ne fonctionne pas.* I am confident that with a clear vision, clear objectives, a clear plan, strong leadership and good management, we can succeed.

The long desired goal of the delivery of health and social services through a seamless continuum of care has now become attainable and it is to be pursued. This is a generational opportunity for McGill and its affiliated health partners – all of us here - to reinvent how we can provide more value to the community we serve. We must seize this opportunity.